DEPOSITION EXCERPTS OF DR. GREGORY SEPANSKI

It is further stipulated and agreed by and between the parties hereto and the witness that the signature of the witness to this deposition is hereby not waived.

* * * * * * * * * * * * * * *

GREGORY J. SEPANSKI, M.D.

The witness, after having first been duly sworn to speak the truth, the whole truth and nothing but the truth testified as follows:

MR. ADAMS: This will be the deposition of Dr. Gregory J. Sepanski taken for use at trial and any other purpose authorized by the Federal Rules of Civil Procedure.

EXAMINATION

BY MR. ADAMS:

Q. Dr. Sepanski, I'm David Adams. You and I have spoken before, and just a few ground rules for the deposition. I see you nodding your head. I do that. Everybody does that. But the court reporter is taking down everything, so make sure a verbal response is given to my questions.

A. Okay.

Q. And, obviously, a yes or no is easier for her to take down than an uh-huh or huh-uh as we

all do in normal conversation, so ...

We are -- I'm just going to ask you a few questions here today. As you know, I represent Kyle Bengston.

I am going to hand you what I'm going to mark as Plaintiff's Exhibit 1.

MR. ADAMS: This will be his affidavit.

(Plaintiff's Exhibit 1 was marked for identification.)

Q. Dr. Sepanski, what I'm handing you is what I'm going to mark as Plaintiff's Exhibit 1. This is an affidavit that you have given in this case. Unfortunately, in addition to being tardy here today, I did not include Exhibit A to this deposition which is your CV, but your office, I guess, has a copy of your CV here?

A. That's correct.

Q. Well, we may or may not get that before we go, depending on what we decide is necessary.

Just can you go over your -- where did you attend undergraduate?

A. Undergraduate was at the University of Wisconsin-Parkside.

Q. Yes, sir. And where did you obtain your medical degree?

A. University of Wisconsin in Madison.

Q. And you are a board certified ophthalmologist; is that correct?

A. Yes.

Q. How long have you been a medical doctor?

A. I graduated from medical school in -- I've got to think back here -- 1990.
Q. Okay. You have been practicing medicine since that time?
A. That's correct.
Q. And you're admitted to practice in the state of Alabama?
A. That's right.
Q. Are there any other states that you are admitted to practice medicine in?

A. Not currently right now.
Q. Okay. What other states have you been licensed in in the past?
A. I was licensed in the state of Georgia and in the state of Texas during residency.
Q. All right. And you have --
A. Or I had an exemption in Texas because it was my residency.
Q. Okay. Yes, sir. And you have also, I believe, served in the military as a medical doctor; is that correct?
A. That's correct.
Q. And which branch of the service were you in, please?
A. The Army.
Q. And how long did you do that?
A. Eight years.
Q. When did your -- When did you complete your duty as a medical doctor in the military?
A. 1998.

Q. All right. When did you become board certified as an ophthalmologist?
A. In 1997.

9

Q. Where did you do your specialized training in ophthalmology?
A. At Brooke Army Medical Center in San Antonio, Texas.
Q. You do treat glaucoma patients as a regular part of your practice; is that correct?
A. That's correct.
Q. The affidavit that I've just handed you which I've identified as Plaintiff's Exhibit 1, what do you recognize that document to be, please?
A. This is the affidavit of Gregory J. Sepanski, M.D.
Q. And that is you, correct?
A. That's me.
Q. And that's your signature?
A. Correct.
Q. You agree that you signed this affidavit?
A. That is correct.
Q. And you signed that before a notary; is that correct?
A. Yes.
Q. All right. You understood that was a sworn statement when you gave it?

10

A. Yes.
Q. Okay. And that it was being used as testimony in a case involving one of your former patients, Mr. Kyle Bengston?

A. Yes.
Q. If you would, in the second paragraph there, you have given your professional opinions. Do you stand by those opinions given in paragraph two as we sit here today?
A. Yes.
Q. All right. Can you tell us, what is the basis for your opinion that Kyle Bengston was suffering from angle closure glaucoma in his right eye -- or let me back up there. Can you just explain your opinions, the ones contained in paragraph two, please.

MR. WHITE: May I interject? When you talk about paragraph two, are you talking about the second full paragraph in the affidavit?

MR. ADAMS: Yes.

MR. WHITE: Okay.

Q. Go ahead, Doctor.

A. Well, I first saw Kyle back --

Is it okay if I look at my notes?

Q. Yes, sir.
A. Can I do that?

Well, I saw -- Kyle first presented to my office on March 7th, 2005. And at that time, Kyle had complaints of blurred vision in his right eye and was having headache problems on and off, had had a previous eye exam several months prior and was actually referred to me by his primary medical doctor.

When I first saw him, his vision in his right eye was at best corrected to 20/30 and 20/20 in the left eye. He had a very elevated intraocular pressure in his right eye, and it was normal in his left eye.

I'm not going to go through the entire exam summary, but he had findings consistent on his exam of angle closure glaucoma. It was in my opinion a secondary angle closure glaucoma as a result of having strips of tissue blocking his drainage angle. And that's called commonly peripheral anterior

synechia, and it was rather diffuse on the right. He had significant optic nerve cupping which can be a sign of damage, and he had a pupillary abnormality called an APD which is also a sign of optic nerve damage.

Q. And APD, what does that stand for?

A. Afferent pupillary defect, and that was in the right eye.

Q. What is afferent pupillary defect indicative of?

A. That is indicative of either extensive retinal damage or extensive optic nerve damage. In his case, he had the optic nerve damage as was seen with the extensive optic nerve cupping.

Q. Now, you are welcome to refer to notes if you have them in front of you. On August the 20th, 2004, Mr. Bengston was seen by -- at the Wal-Mart optometry office in Opelika. Are you aware of what his optic nerve cupping was on

that day? And I'll give you a minute just to get to those notes, or I can -- I can certainly provide it to you.

A. August 20th, 2004?

13

Q. Yes, sir.

A. The cup-to-disc ratio -- this, I believe, is Dr. Bazemore's note. He had put down .4.

Q. Okay. And when you saw Mr. Bengston in March of 2005, on March 7th, 2005, what was Kyle Bengston's cup-to-disc ratio in his right eye?

A. .8.

Q. And what is -- That increased cup-to-disc ratio from August to March, what is that indicative of?

A. That was a result of the elevated intraocular pressure, and it usually signifies that there is loss of nerve fibers in the optic nerve, meaning optic nerve damage.

Q. Is this -- This optic nerve cupping that had gone up to .8 when you saw him from .4 and the APD, is that indicative of high intraocular pressure occurring over an extended period of time?

A. Yes.

Q. And can you explain that, please.

A. Well, usually, in order -- an APD can happen in a very brief period of time if there is a

14

sudden traumatic injury to the optic nerve, but it usually comes about -- since most

diseases are kind of chronic in nature, it usually comes about over time, so ...

Q. Based on your affidavit, it was not your opinion that Kyle was suffering from a sudden traumatic --

A. No, he was not.

Q. Okay. The last sentence of the second paragraph of your affidavit said that Mr. Bengston was absolutely not suffering from an acute angle closure attack when you saw him for the first time in March of 2005.

A. That is correct.

Q. Moving on to the third paragraph of your affidavit, if you would, please, just read that opinion, and what I'm going to say to the jury -- that's just because this may be read later on by a jury when this case goes to trial. So if, in fact, it is, if you don't mind, read the opinions contained in paragraph three to the jury, please.

A. Based upon Wal-Mart optometry exam notes of

August 20, 2004, Mr. Bengston had an unexplained diminished best corrected visual acuity in his right eye. At the time of the August 20, 2004, exam, he was in all probability suffering from subacute angle closure glaucoma.

Q. Is that your opinion as we sit here today?

A. Yes.

Q. I'm sorry?

A. Yes. Yes, it is.

Q. What is the basis of that opinion?
A. Well, I had the luxury of being able to see him later on in several months when he was obviously having trouble with angle closure. I felt as though when he was seen on the exam --

If you look at Dr. Bazemore's note in August 2004, his pressure was normal. Pupils were regarded as normal. Optic nerves were regarded as normal. But the most troubling thing was that he had complained of halos, and he also had diminished vision in that eye where it was previously normal, and there

really was no explanation given as to why that was.

And as I said here on the bottom, I felt as though he needed to at the very least be sent for a second opinion to be able to figure out what exactly was going on, even if he didn't find something wrong.

Q. Okay. Where there's an unexplained diminished best corrected visual acuity, that's something that in your practice you would follow up on?

MR. WHITE: Object to leading.

Q. You can go ahead. What would you do if a patient had an unexplained diminished best corrected vision?
A. I would bring them back to repeat different aspects of my exam. I might order some additional tests. If I could not figure out

why they weren't seeing as well as they should, I would refer them to somebody else to get a second opinion.

Q. The bottom statement there where you state had Mr. Bengston been referred for ophthalmic evaluation on August 20, 2004, his vision in

all likelihood would have -- his vision loss, excuse me, in all likelihood would have been prevented. As we sit here today, is that -- does that continue to be your opinion?

A. Yes.

Q. If Kyle Bengston had been referred to you in August of 2004, what would you have done?

A. I would have repeated a full eye exam on him and just looked to see if I could find an explanation for what is his diminished vision. That may or may not have led me to doing an immediate gonioscopy, but he clearly needed more evaluation and more tests done, so ...

Q. Okay.

A. It just would have depended on what I had seen on him at that particular time.

Q. And is intermittent, or as is sometimes referred to as chronic angle closure glaucoma, is that something that is treatable?

A. Yes.

Q. And if a patient has that condition, can vision loss be prevented?

A. Yes.

Q. How do you treat a patient with that condition? And I understand no two patients are exactly alike, but just tell -- if you would, explain how patients with that condition are often treated.
A. With the intermittent angle closure?
Q. Yes, sir.
A. Usually they're treated with a combination of laser peripheral iridotomy and topical eyedrops to control the eye pressure.
Q. Okay.
A. Sometimes they require surgery if the pressure is not controllable with the first two.
Q. All right. Do you have an opinion as to whether -- Let me ask you this. Is it possible that Kyle Bengston might have been able to avoid surgery if he had seen an ophthalmologist earlier?
MR. WHITE: Object to the form.
Q. You can go ahead and answer. It's just a lawyer thing.
A. I think that given that -- knowing what I know

now, with the type of glaucoma that he had, he probably would have needed surgery in the end anyway, but sometimes you are able to avoid having to do surgery.
Q. Okay. Could his vision loss have been prevented?
A. Absolutely.
Q. You've testified a little bit earlier that as

a common part of your practice, you see patients with glaucoma; is that correct?

A. That's correct.

Q. In your experience, what limitations -- I'll tell you what. Let me -- I'm not asking this the right way.

You have other patients who have -- who've lost vision in one eye; is that correct?

A. That's correct.

Q. Okay. And based on your experience in treating those patients, what limitations do those patients have?

A. Well, some are not able to continue with their job/career that they have. For example, if

they're a pilot, they can't --

MR. WHITE: We object to the form.

A. -- they can't be a pilot anymore. Some are not able to drive, although most -- most states in the United States allow people to drive legally with just one eye, so usually driving is not too much of a problem, but career change is one of the biggest ones.

Q. Okay. Any lifestyle changes that you typically see with individuals who have lost just about all their vision in one eye?

A. Well, they have to be certainly more cautious. They have to -- you know, they can't do certain lifestyle activities. If they are enjoying karate or soccer or other sports endeavors, they have to be a lot more

leery that they have one eye and should they sustain an injury to that eye, it may have devastating effects on their lifestyle. They certainly have to be leery of that.

Q. As far as my -- let me just ask it. Have I retained you as an expert in this case?

A. No.

Q. And, in fact, have I through today paid you for any conversations or --

A. No.

Q. -- anything that -- any communication that you and I have had?

A. No.

Q. Or for your involvement in this case at all?

A. No.

MR. ADAMS: I don't have anything else at this time.

EXAMINATION

BY MR. WHITE:

Q. Dr. Sepanski, I'm Matt White. I'm one of the lawyers for Dr. Bazemore. We met previously, and I want to ask you some questions -- follow-up questions as well.

Mr. Adams just asked you about whether you have -- whether he has paid you any monies for your services. I wanted to ask you, how many times prior to this deposition today have you either spoken with or met with Mr. Adams?

A. We had lunch together twice.

Q. Where did that occur?